



IDAHO DEPARTMENT OF HEALTH & WELFARE

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CERTIFIED FAMILY HOME PROGRAM

CERTIFIED FAMILY HOME (CFH) MEDICATION AUTHORIZATION

www.cfh.dhw.idaho.gov

Provider Name _____ Date _____

Participant Name _____ Date _____

RE: Medication Authorization

Dear Health Care Provider:

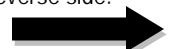
Assistance with Medications. The certified family home must provide assistance with medications to residents who need assistance; however, only a licensed nurse or other licensed health professional may administer medications.

The rules governing Certified Family Homes specify that I must obtain certain directions from my physician regarding the administration of medication. I would appreciate your completion of the following questions:

- ☐ Yes ☐ No 1. **This patient is able to self-administer all medication.** The patient understands the purpose of the medication; knows appropriate dosage and times to take the medication; understands expected side effects, adverse reactions or side effects, and action to take in an emergency; and is able to take the medication without assistance.*
- ☐ Yes ☐ No 2. **This patient requires assistance with taking both routine and non-routine medications.**

* For these purposes, assistance means reminders, assisting with removal from container and observing the taking of the medications. No other functions of medication administration are allowed unless the provider meets requirements of the Board of Nursing. *The physician's signature authorizes UAP to assist with both routine and non-routine medication as prescribed, along with provision of defined criteria for non-routine medication.*

**PLEASE RETURN THE SIGNED FORM TO THE CFH PROVIDER LISTED
AT THE TOP OF THIS FORM.**



AUTHORIZATION FOR OVER THE COUNTER (OTC) MEDICATIONS

The listed resident lives in a Certified Family Home (CFH). The CFH provider is required to obtain written consent by the resident's licensed medical professional before giving any medications. Please identify recommended standard OTC medications that are most appropriate for the resident's specific medical needs.

Standard OTC Medications

- Pain Reliever: _____
- Antacid: _____
- Cold / Sinus: _____
- Anti-Diarrhea: _____
- Stool Softener: _____
- Supplements / Herbs: _____
- Vitamins: _____
- Other: _____

Comments:

Health Care Provider's Signature _____ Date _____